# The Commonwealth of Massachusetts
## Division of Professional Licensure
**BOARD OF REGISTRATION OF SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY**
239 CAUSEWAY STREET
BOSTON, MA 02114
(617) 727-1747
WWW.STATE.MA.US/REG/BOARDS/SP


**BOARD OF REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY**

## **FORM 1** - SUPERVISED PROFESSIONAL PRACTICE PLAN

**THIS PLAN MUST BE COMPLETED, SIGNED, AND RETURNED TO THE BOARD OFFICE WITHIN THIRTY (30) CALENDAR DAYS OF THE START OF YOUR SUPERVISED PROFESSIONAL PRACTICE TO BE CONSIDERED.**

**INSTRUCTIONS:**
- **TYPE OR PRINT IN INK**
- **PLEASE READ CAREFULLY BEFORE COMPLETING**
- **ANSWER ALL QUESTIONS. WRITE "NOT APPLICABLE" IF NO OTHER RESPONSE IS APPROPRIATE**
- **USE ADDITIONAL PAGES IF NECESSARY**
- **IF SUPERVISOR CHANGES PLEASE SUBMIT A FORM II TO COMPLETE THAT PORTION OF THE CFY, NEW SUPERVISOR NEEDS TO SUBMIT A NEW FORM I/FORM II WHEN COMPLETED.**

**TO BE COMPLETED BY APPLICANT**

**1. AREA OF LICENSURE ( )AUDIOLOGY ( )SPEECH-LANGUAGE PATHOLOGY**

**NAME:**_____
**(last) (first) (middle)**
**ADDRESS:**_____
**(number) (street)**
_____
**(city) (state) (zip code)**
**SOCIAL SECURITY NUMBER:** ____ ____ ____ - ____ ____ - ____ ____ ____ ____

**PHONE:**_____ _____
**(business) (home)**

**2. PROFESSIONAL PRACTICE RESPONSIBILITIES**
**List approximate number of hours per week to be spent in each activity.**

**ACTIVITIES/HOURS PER WEEK**

**A. Diagnostics**_____
**B. Therapy (totals)**_____
**1. language disorders**_____
**2. articulation disorders**_____
**3. voice disorders**_____
**4. fluency disorders**_____
**C. Aural Rehabilitation**_____

**D. Identification and Evaluation of Hearing Impairment**_____
**E. Record Keeping**_____
**F. Staff Meetings**_____
**G. In-Service Training**_____
**H. Other (explain)**_____

**3. PROFESSIONAL PRACTICE EMPLOYMENT INFORMATION SPP PLAN 2**

**A. Employer**_____
**(company name) (division or department)**
**Address**_____
**(number) (street)**
_____
**(city) (state) (zip code)**
**B. Beginning date of employment**_____
**C. Date Supervised Professional Practice to start**_____
_____
**D. Date Supervised Professional Practice to end**_____
_____
**E. Number of hours per week in: Audiology**_____ **Speech-Language Pathology**_____

**4. STATE OF THE APPLICANT**

**I HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THE PERSON NAMED BELOW**
**AND AGREE TO ITS IMPLEMENTATION.**

_____ _____
**(applicant's signature) (date)**

**TO BE COMPLETED BY SUPERVISOR**

**NAME:**_____
**(last) (first) (middle)**
**ADDRESS:**_____
**(number) (street)**
_____
**(city) (state) (zip code)**
**PHONE:**_____ _____
**(home) (business)**
**SOCIAL SECURITY NUMBER:** _____ - ____ - _____

**5. LICENSURE STATUS**
**A. Massachusetts Licensure Status: Audiology#**_____
**Speech-Language Pathology#**_____

**B. Expiration date of license/renewal**_____

**NOTE: IF OUT-OF-STATE, INDICATE ASHA-CCC, OR LICENSURE IN STATE OTHER THAN MASSACHUSETTS.**

**CCC**_____
**(Speech-Language Pathology or Audiology) (membership#) (date issued)**
**License**_____

**(state in which license is held)** **(license#)** **(expiration date)**

**6. SUPERVISION**

**THE SUPERVISED PROFESSIONAL PRACTICE SUPERVISOR MUST BASE THE TOTAL EVALUATION ON NO LESS THAN 36 OCCASIONS OF MONITORING ACTIVITIES (A MINIMUM OF FOUR HOURS EACH MONTH). THESE MONITORING ACTIVITIES MUST INCLUDE AT LEAST 18 ON-SITE OBSERVATIONS (A MINIMUM OF TWO HOURS EACH MONTH).**

**SPP PLAN 3**

| METHODS | SESSIONS/MONTH | LENGTH/SESSION | ACTIVITY(see 2) |
|---|---|---|---|
| **A. On site observations** | _____ | _____ | _____ |
| **B. Remote observations** | _____ | _____ | _____ |
| **(audio, video tape)** | _____ | _____ | _____ |
| **C. Conferences (phone)** | _____ | _____ | _____ |
| **D. Review of Records** | _____ | _____ | _____ |
| **1. therapy plans** | _____ | _____ | _____ |
| **2. diagnostic reports** | _____ | _____ | _____ |
| **E. Staff Meetings** | _____ | _____ | _____ |
| **F. Case Staffings** | _____ | _____ | _____ |
| **(placement meetings)** | | | |

**7. STATEMENT OF SUPERVISOR**

**I HEARBY CERTIFY THAT ALL STATEMENTS MADE BY ME IN RELATION TO THIS PLAN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF. I FURTHER CERTIFY THAT I UNDERSTAND THE RESPONSIBILITIES OF A SUPERVISOR AS STATED IN THE RULES AND REGULATIONS OF THE MASSACHUSETTS BOARD OF REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY (260 CMR).**

_____

**(supervisor's signature)** **(date)**